gentlich muss man sagen, dass der dänische
enn das Sozialministerium zeigt viel mehr
konie als die dänische Kirche und Gemein-

eitdem geändert. Es gibt heute ein größeres
Obwohl dies nicht zugleich das Interesse an
ließt, findet man heute in vielen Gemeinden
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ov/Jørgensen, Anja, *Filantropi, selvhjælp*
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ke velfærdsstat – gennem fire socialreformer
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eller lappeskrædder? Kirkens Korshær 1912-

sygeplejeordner i Danmark efter reformatio-
05: 1-2, 88-105.

i nyere dansk diakoni, København 2002.

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ig rationalitet og særlige arbejdsmetoder?, *So-*

det 1998, 76.

Caritas in Belgium: Retaining a vigorous presence by adapting and modernising?

Jan De Maeyer und Jo Deferme

For the subject matter of this study, that is the changes in the confessional welfare networks in the 1960s, Belgium appears to be a particularly interesting case. Indeed, in Belgium, Catholics in general and the religious orders and congregations in particular, have always been very active in social work. A glance, for example, at the number of hospitals connected to the *Verbond van Verzorginginstellingen* (VVI), a subsection of *Caritas Catholica*, speaks volumes in this regard. In Belgium the 1960s brought profound changes in this field. The further elaboration of the welfare state in this period provided numerous challenges for the Catholic practices and ideas about Caritas and "*Diakonie*". This article starts with a short introduction to Catholic and congregational social work before the 1960s, after which follows a brief outline of the general development of modernisation in the 1960s: the democratisation and emancipation of society, the professionalization and medicalisation of health care. Then, the changes and developments of the 1960s in the specific realm of Catholic social work and congregational activities will be presented along thematic lines: first, what impact did the *decrease of the number of religious people* (e.g. congregation members) and consequently, increased lay participation have on Catholic and congregational *identity*; second what were the *organisational* developments in both the religious institutions and the state; and third, what was the impact of increasing *professionalization*? In the conclusion, all relevant information will be reconsidered in order to provide a specific answer to the five questions formulated in the conference's call for papers.[1]

Historical overview of Catholic and congregational social work, 1830-1950s

In Belgium, Catholics have been active in the field of charity and social work for a long time. It was only in the second half of the 18th century (cf. the Enlightenment) that the notion of "public charity", the conviction that the state had to protect the well-being of its citizens, became widespread. Still, even in the 19th century, charity remained a domain largely controlled by the church and Catholic organisations.

[1] A general introduction about this theme: Jähnichen, Einleitung, in: Jähnichen/ Friedrich/ Witte-Karp, *Auf dem Weg in dynamischen Zeiten,* 9-20; Henkelmann/ Kaminsky, Konfessionelle Wohlfahrtspflege und moderner Wohlfahrtsstaat, in: ibid., 253-283.

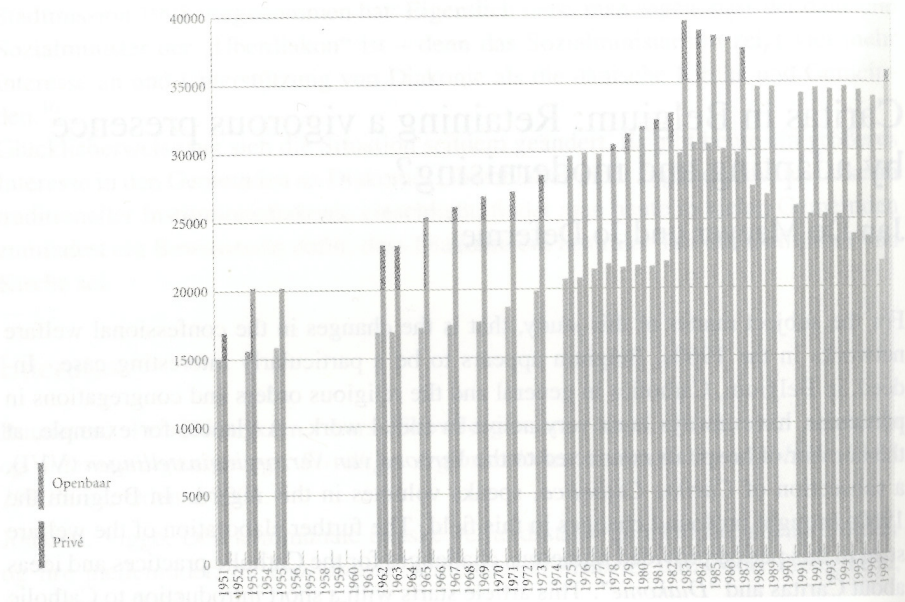


Figure 1: Number of beds in public (grey) and private hospitals (dark) in Belgium, 1951-1997. Source: De Maeyer, J., a.o. *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen*, p. 334.

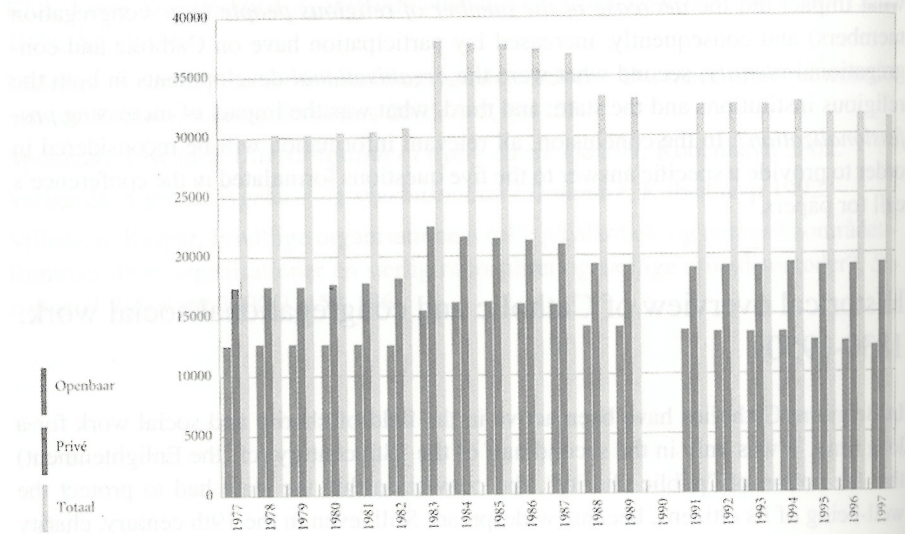
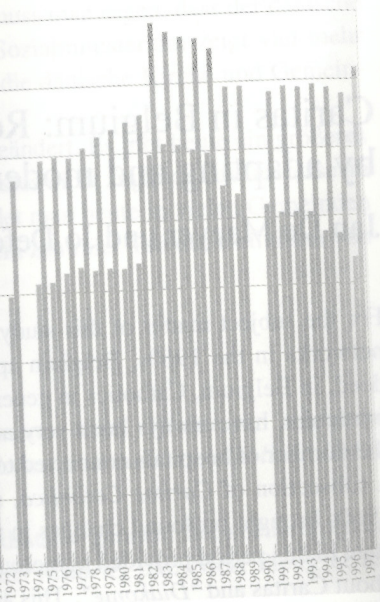
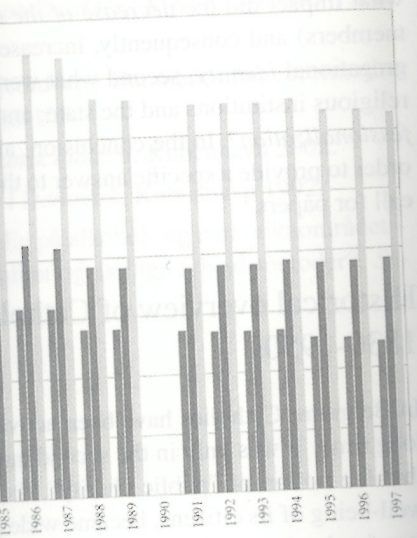


Figure 2: Number of beds in public (light dark) and private (dark) hospitals in Flanders, 1977-1997. Source: De Maeyer, J., a.o. *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen*, p. 334.



pitals (dark) in Belgium, 1951-1997. Source:
Tweehonderd jaar gezondheidszorg in Vlaan-



private (dark) hospitals in Flanders, 1977-1997.
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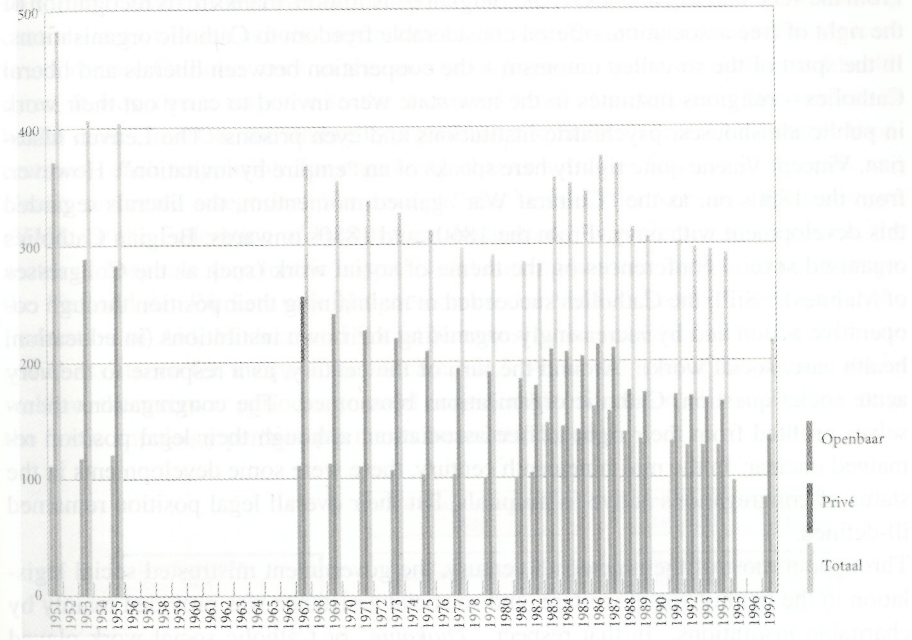


Figure 3: Number of hospitals (public = light dark; private = dark) in Belgium, 1951-1997. Source: De Maeyer, J., a.o. *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen*, p. 335.

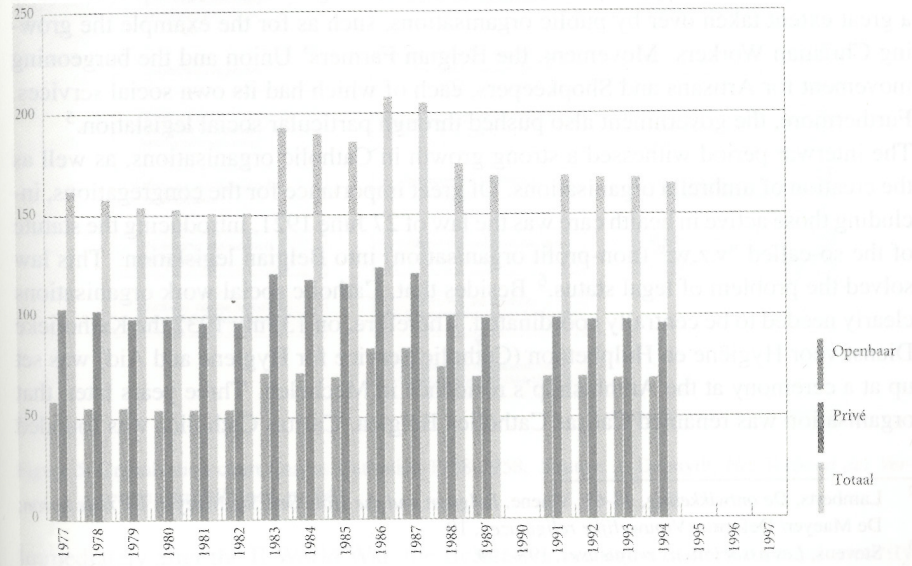


Figure 4: Number of hospitals (public = light dark; private = dark) in Flanders, 1977-1997. Source: De Maeyer, J., a.o. *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen*, p. 335.

From the very start in 1830-1831, the Belgian constitution, thanks to its recognition of the right of free association, offered considerable freedom to Catholic organisations. In the spirit of the so-called unionism – the cooperation between liberals and liberal Catholics – religious institutes in the new state were invited to carry out their work in public almshouses, psychiatric institutions and even prisons. The Leuven historian, Vincent Viaene quite rightly here speaks of an "empire by invitation". However, from the 1850s on, as the "Cultural War" gained momentum, the liberals regarded this development with envy. From the 1860s and 1880s onwards, Belgian Catholics organised several conferences on the theme of social work (such as the Congresses of Malines).[2] Still, the Catholics succeeded in maintaining their position through cooperative action and by increasingly organising their own institutions (in education, health care, social work). Around the turn of the century, as a response to the very acute social question, Catholic organisations blossomed. The congregations themselves profited from their right to free association, although their legal position remained unclear. In the mid-nineteenth century, there were some developments in the status of congregations active in hospitals, but their overall legal position remained ill-defined.[3]

Throughout most of the nineteenth century, the government mistrusted social legislation in the field of social welfare, and so social assistance was provided mainly by charitable institutions. In that respect, "*Diakonie*" or Catholic social work played a role that can hardly be overemphasized. From the 1880s onwards, the state expanded its social legislation and thus did not rely exclusively on charity anymore.[4] This meant that private charity (for example, the Society of St. Vincent de Paul), which had grown enormously ca. 1850 -1880, now began to decline. Its role was to a great extent taken over by public organisations, such as for the example the growing Christian Workers' Movement, the Belgian Farmers' Union and the burgeoning movement for Artisans and Shopkeepers, each of which had its own social services. Furthermore, the government also pushed through particular social legislation.[5]

The interwar period witnessed a strong growth in Catholic organisations, as well as the creation of umbrella organisations. Of great importance for the congregations, including those active in health care was the law of 27 June 1921, introducing the statute of the so-called "v.z.w." (non-profit organisation) into Belgian legislation. This law solved the problem of legal status.[6] Besides that, Catholic social work organisations clearly needed to be centrally coordinated. Therefore, on 13 July 1932 the Katholieke Dienst voor Hygiëne en Hulpbetoon (Catholic Service for Hygiene and Aid) was set up at a ceremony at the Archbishop's residence in Mechelen. Three years later, that organisation was renamed Caritas Catholica Belgica. Caritas Catholica was founded

2 Lamberts, *De ontwikkeling*, 48-63; Viaene, *Belgium and the Holy See;* De Maeyer, *De rode baron*; De Maeyer/ Deferme, *Vrouwelijke religieuzen*, 10.

3 Stevens, *Les associations religieuses*, 198-199.

4 Deferme, *Uit de ketens van de vrijheid*, passim.

5 De Maeyer, Katholische Soziallehre, in: Hiepel/ Ruff, *Christliche Arbeiterbewegung in Europa*, 99-119; *De Belgische Volksbond en zijn antecedenten*, 18-65.

6 Stevens, *Les associations religieuses*, 201.

on the initiative of the ecclesiastical hierarchy itself, and was part of the increasing centralisation within Catholic organisations. It was devised as an umbrella structure to coordinate Catholic work in the sectors of hygiene, social assistance and health care. It was also a response to the increased level of government intervention in health care. In 1938, the umbrella organisation split into several Verbonden (Federations), each responsible for organising charity activities for several, specific and clearly separated categories. For example, the Verbond der Verplegingsinstellingen (V.V.I., or the Federation of Health Care Institutions) was created to coordinate the sector of hospitals, psychiatric hospitals and nursing homes.[7] In the field of welfare, the Verbond der Werken voor Hulpbetoon en der Medico-Sociale Diensten (or the Federation of Aid, Medical and Social Services) was created in 1940 to coordinate social assistance for the poor, home care, etc.[8] As to the role of the state in social welfare, the interwar period witnessed considerable expansion of social policy (e.g. the first compulsory pension payments were introduced).

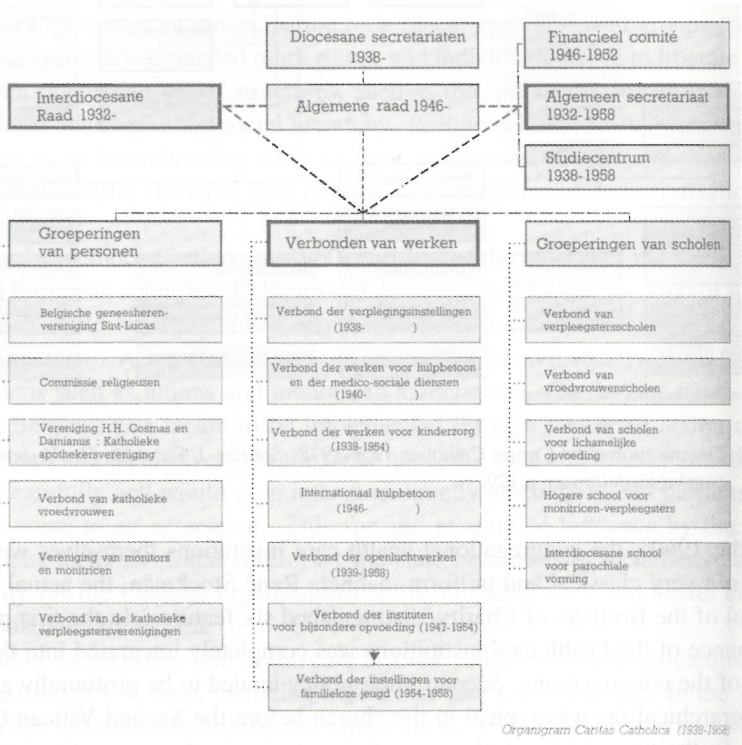


Figure 5: Organisation chart Caritas Catholica 1938-1958. Source: J. Depuydt, *Het Verbond der Verzorgingsinstellingen*, p.104.

Immediately after the II.World War, the Belgian government started a social security system, thereby providing a strong institutional framework for the world of welfare

[7] Dhaene, *Stichting en uitbouw*, 85.
[8] Ibid.

and health care. For the Catholic health care institutions, the umbrella organisation Caritas and its federations remained important players. In August 1957 Cardinal Van Roey appointed Fr. Albert Cauwe as the new director-general of Caritas. The organisation had been experiencing several problems and now the ecclesiastical hierarchy tried to cope by intervening directly. Fr. Cauwe was given the task of reorganising the structures of Caritas, with the ultimate aim being to restore cohesion and cooperation within the organisation. On 17 December 1957, the Belgian bishops approved his report. In a period of four months, Cauwe succeeded in restructuring Caritas, accomplishing his goal to simplify the organisation into a strongly hierarchical and pyramidal structure.[9]

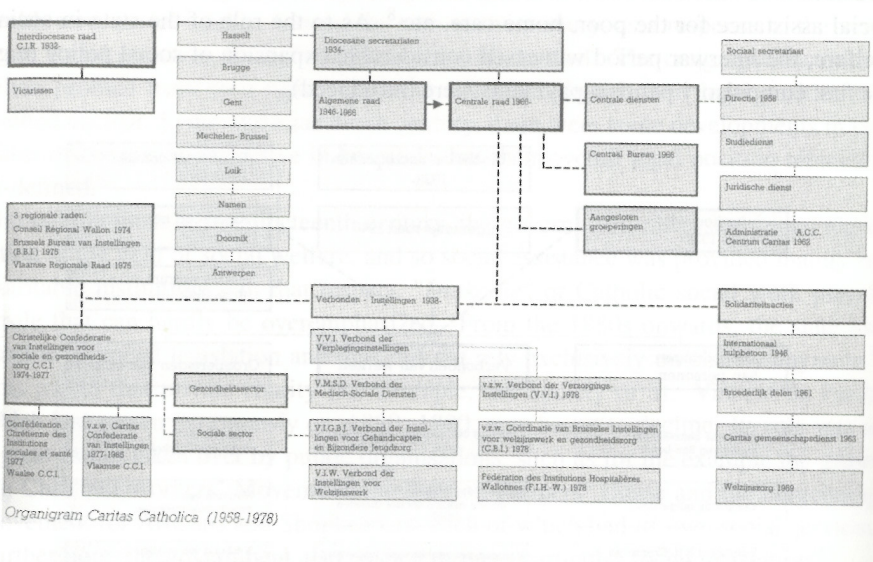


Figure 6: Organisation chart Caritas Catholica 1958-1978. Source: J. Depuydt, *Het Verbond der Verzorgingsinstellingen*, p.129.

Until the 1960s, the congregational health care institutions themselves were structured in a very classical and uniform manner. René Stockman, the actual Superior General of the Brothers of Charity, distinguished six features. In the first place, the governance of the health care institutions was completely integrated into the governance of the congregations. Second, their policy tended to be profoundly autocratic and hierarchical (as was typical in the church before the Second Vatican Council). Third, on the financial level, the vow of poverty inspired congregations to be very economical also in their health care policies. Fourth, the general aims of the congregations' social work and health care were intricately linked with the goals of the life of the cloister, the ultimate goal being a religious one. Fifth, although several sisters possessed degrees from nursing schools, generally speaking their level of education tended to be lower than that of nuns active in education. Finally, although there was

9 Depuydt, *Ontplooiing*, 130, passim.

initially little cooperation between the Catholic institutions, in the 1930s umbrella organisations such as Caritas Catholica were created to coordinate Catholic charity and social work.[10]

The general changes of the 1960s: several forms of modernisation in society and health care

The 1960s indeed proved to be a profoundly dynamic period, witnessing extensive modernisation both in society generally (democratisation and emancipation) and in the field of medicine and health care (professionalization of health care in the framework of the welfare state).

These years were labelled the Golden Sixties. In the socio-political domain, they witnessed the heyday of the welfare state, when social security and health care was made accessible to an increasingly large number of citizens. On the socio-cultural level, several processes of emancipation took place: specific social groups (such as women and students) demanded more rights, and individuals strove to liberate themselves from oppressive social structures, such as the 'pillarised' institutions. Individual choice challenged the social hierarchy. Religious belief shifted from being a tradition or habit towards being more an issue of personal choice. All these social developments will be clustered here into the two categories of democratisation and emancipation.

With regard to democratisation, the 1960s constituted the heyday of the welfare state in several European countries. Belgium had developed a very specific kind of welfare state, which could be labelled as "corporatist" (cf. the classical categorisation of Esping-Andersen). A key feature was the strong role in civil society of all kinds of organisations such as unions and mutual aid associations. On the one hand, social policy in Belgium was meant to be implemented through concerted action among the social partners themselves. On the other hand, the state continued to monitor all decisions carefully and would even intervene directly when the social partners were unable to come to an agreement. This specific mixture of influence by the social organisations themselves and control by the state became both a challenge and an opportunity for the Catholic organisations active in social work and health care, as will be illustrated further on.

In the field of social policy and health care in 1944-1945, the Belgian government set up a social security system, including health care and social welfare. In the 1960s, decisive steps were taken to rethink and especially *expand* social security and welfare. In the field of health care, the compulsory nature of medical insurance boosted the demand for health care. Hospitals became accessible for everyone and the ability to pay for care became less dependent on a person's economic situation. Although initially that legislation applied only to wage earners, from the 1960s onwards the idea spread that health care was something that had to be provided for everyone in society, including other categories such as the self-employed. Therefore, during

[10] Stockman, *Inleiding*, 13-14.

the 1960s, several crucial steps were taken in the realm of health care. In 1960, the socialist minister of Social Affairs Leburton assembled a round table conference that would ultimately lead to a profound reorganisation of health care, the so-called Leburton law of 1963. Compulsory health care was extended to the self-employed and the specific category of the so-called WIGW's (widows, handicapped persons and orphans) received extra financial benefits. Also in 1963, a new law on health care institutions brought about a profound change in the hospital landscape. Because of the huge expansion of hospital care, legislation in the early 1970s (the Nameche law of 6 July 1973) was mainly oriented towards ensuring financial responsibility.[11]
In the field of welfare also, there was a very important evolution. We have already shown how in the 1960s the idea gained ground that social security had to be extended to all citizens. In the period 1945-1963 social security (broadly interpreted) distinguished between social security (family benefits, health care, unemployment, pensions) on the one hand, and social assistance or the so-called "residuary systems" (benefits for the disabled, income guarantees for the elderly) on the other hand. So, the system of social assistance was intended to help those who slipped through the "social security net". Social assistance did not belong to social security in the strict sense, but was part of the overall social protection of the Belgian population. It was financed by taxes and was not salary based. Another difference was that social assistance was organized on the local level. In the early 1970s the legislature, while not abolishing the distinction between assistance and security, enhanced these so-called residuary systems of social assistance, e.g. by transforming the COO (Centra voor Openbare Onderstand) into the OCMW (Openbare Centra voor Maatschappelijk Welzijn), or by providing a subsistence income (*bestaansminimum*, August 1974).[12]
We will discuss later whether this change in perception and in the organisation of the relationship between social security and social assistance had any implications for Catholic "*Diakonie*" (social welfare work).
Democratisation also spread within the Catholic world. Within the Church, Vatican II introduced a shift from monologue towards greater dialogue.[13] In the congregations too, greater freedom and more democratic forms of governance were introduced (cf. infra).[14]
The 1960s also witnessed the emancipation of several social groups and individuals (women, students ...), sometimes with important implications for the Catholic world. The obvious identification of citizens with "their" respective pillars and the corresponding values weakened and gave way to individual emancipation. Individuals increasingly wanted to choose for themselves - for instance for whom to vote. The choice of associations and clubs increasingly became a matter of individual decisions. A similar evolution took place in (citizens' attitudes towards) the church, revealing a shift from "ecclesiastical Catholicism" to "vague social-cultural Christianity".[15]

11 Doms en Hertecant, *Het gezondheidsbeleid*, 274.
12 Deleeck, *De architectuur*, 375.
13 Fiolet, *De Kerk op de kruispunten*, 103.
14 De Maeyer, Introduction, 25; Suenens, *Eén van hart en één van ziel*, 419.
15 Hellemans, *Strijd om de moderniteit*, 207-237; Stockman, *Inleiding*, 15.

Also the Catholic pillar as a whole experienced the influence of these processes of emancipation. Pillarisation can be defined as "a profound organisation of everyday life along ideological lines, thereby creating separate worlds or pillars, transacting on their own or through individual member organisations with the state". Pillarisation started in the later 19th century and boomed in the interwar years. Catholics in Belgium were born within the confines of their 'pillar', which accompanied them from the cradle to the grave. From the 1960s onwards, however, the authority of the church and, correspondingly, the profoundly Catholic nature of the 'pillar' were challenged. Still, as a sphere of influence 'pillarisation' did not collapse by any means. In part because of their role in the welfare state, the pillars retained their influence in Belgium.[16]

Next to Catholic societal structures, also Catholic *thinking* was influenced by these emancipatory tendencies. Theology witnessed the increasing popularity of non-traditional views, for example feminist and ecologist Christology.[17] On the other hand, it is not unfair to say that there actually was a religious crisis in the 1960s and that the congregations had to face the challenges of both a numerical decline and a crisis of identity.[18]

Finally, two developments in the modernisation of health care deserve closer scrutiny: professionalization and medicalisation. Partly due to the welfare state, health care became profoundly professionalised from the 1960s onwards. Professionally trained physicians gained influence and medical specialism boomed. Hospitals ceased to be mere institutions of rest and recovery (as was the case in the old sanatorium), and focused on professional medical activities. In Belgium in the 1960s there was a vast expansion in the world of hospitals. From the 1960s onwards (and mainly in the 70s and 80s) there also was the development of medicalisation, "a process by which non-medical problems become defined and treated as medical problems", the classic example being the medicalisation of childbirth.[19]

All these developments exercised a profound impact on the role of religious institutions in health care and welfare.

Catholic and congregational social work in the 1960s

In the 1960s, the Church and Catholic organisations had to face a vast number of challenges and even experienced a real religious crisis.[20] Obviously, numerous changes were introduced by the Second Vatican Council, as we mentioned already. In the specific field of social care, for instance, the Council reinvented and innovated the concept of "*Diakonie*". Traditionally, the "*Diakonie*" in general denoted "a service particularly of the poor, widows, orphans, pilgrims, and strangers, organized by the

[16] Huyse, *De verzuiling voorbij*, 17; Hellemans, *Strijd om de moderniteit*, 245.
[17] Burns, *Roman Catholicism after Vatican II*, 24-25.
[18] Wynants, *La vie consacrée*, 166.
[19] Gabe, *Key concepts*, 59; Conrad, *The medicalisation of society*, passim; Berridge/ Webster, *Mobilisation for total welfare*, 173.
[20] McLeod, *The religious crisis of the 1960's*, passim.

Church in a systemic fashion". Throughout the ages, the specific interpretation of the notion had evolved according to the needs of the era. Still, within the Catholic Church, the notion had lost its prominence for ages, and was replaced by the concept of "caritas", until in 1964 the Second Vatican Council organised "a re-foundation of "*Diakonie*". The famous Council document *Gaudium et spes*, for instance, pointed out that the Church did not longer aspire to rule the world, but rather to serve, and in that respect also accepted a pluralistic society[21]

With regard to the specific challenges for the church and the congregations in Belgium, we will discuss, first, the challenges of decreased religious and increased lay input in Catholic social workfor Catholic and congregational *identity*, second the *organisational* developments in both the religious institutes and the state, and finally the *professionalization* of health care.

Religious vs. lay participation and Catholic identity

The 1960s witnessed secularisation and "the weakening of the collective identities rooted in confessional and ideological subcultures".[22] Churches suffered a decline in Mass attendance. Belgium too, which had a fairly high level of religious practice until the 1960s, also witnessed a severe decline from the mid 60s onwards.[23] Generally speaking, the decline in the membership of congregations also started in the mid '60s.[24] To illustrate the numerical decline: the Gasthuiszusters of Lier (a city near Antwerp) received only a couple of new members in the decades after November 1967.[25]

Gradually, the church gave up its attempts to form an anti-modern society and evolved towards "a more open Christianity within modernity", as the Belgian sociologist of religion Staf Hellemans put it, including an enhanced role for lay people.[26] The increased need for lay collaborators was necessitated by the decreasing number of religious. Furthermore, the number of congregation members active in health care (and education) also declined because they expanded their activities into other ministries, including the promotion of peace and justice.[27] In any case, lay people were no longer considered to be second-rate believers but began to play a central role in ecclesiastical life. In the specific field of health and welfare, lay people were in a way promoted from being helpers in need to being fully-fledged members of staff, both in care and in governance.

Changes also occurred to the notion of "*Diakonie*". Indeed, a specific evolution in the 1960's was that the lower number of priests necessitated an enhanced role for

21 *New Catholic Encyclopedia*, vol.4, 718; Meeuws, *Diakonie als godsontmoeting*, 596-597; *Diaconie in het leven van de parochies*, 10; *Kerk, ambt, diakonie*, 14; Nissen, *Modellen van diaconie*, 3.

22 McLeod, *The religious crisis of the 1960's*, 73.

23 Ibid., 202.

24 Burns, *Roman Catholicism after Vatican II*, 70.

25 Suenens, e.a., *Eén van hart en één van ziel*, 413.

26 Hellemans, *Strijd om de moderniteit*, 193; Hellemans, *Het tijdperk van de wereldreligies*, 187.

27 Burns, *Roman Catholicism after Vatican II*, 70.

Male religious and secular priests in Belgium	
1910	10.376
1920	9.858
1930	11.082
1947	12.725
1961	10.039
1973	5.118

Source: André Tihon, Les religieuses du XVIII au XX siècle, p.35.

Female religious in Belgium	
1910	47.419
1920	44.180
1930	47.891
1947	49.624
1961	44.669
1973	34.685

Source: André Tihon, Les religieuses du XVIII au XX siècle, p.32

Table 1: Tables decline in membership of religious institutions

lay helpers.[28] More specifically, the Second Vatican Council revalued the office of the diaconate, that throughout the ages had been narrowed down within the Catholic Church to a merely liturgical function. In the 1960's, however, the function of deacons was revalued and its social function restored.[29] Also in Belgium, the parishes increasingly called upon the help of deacons. Moreover, it belonged to the deacons' task not to limit the "*Diakonie*" to a task of itself, but rather to spread the idea that it was a task for every member of the Christian community, including lay people in the broadest sense.[30]

Still, increased lay involvement was not easily accepted by the religious. Within the congregational health care institutions themselves, the religious sometimes criticised lay people for their attitude, as will be illustrated later. On a higher organisational level, Caritas Catholica and its federations reacted by emphasising anew the specifically religious character of their care. In 1970, the views of Caritas on "Welfare and well-being" were presented in a text by Marcel Van Lommel, a member of the task force Caritas had installed to study that subject matter. Van Lommel stated that, on the one hand, the professionalization of welfare was a good thing if it enhanced care. Yet, on the other hand, he stated that "more than ever before, religious people had

[28] *Kerk ambt diakonie*, 15.
[29] *Christelijke encyclopedie*, 421; Meeuws, *Diakonie als godsontmoeting*, 589.
[30] Vanormelingen, *De diaconie van de Kerk*, 3.

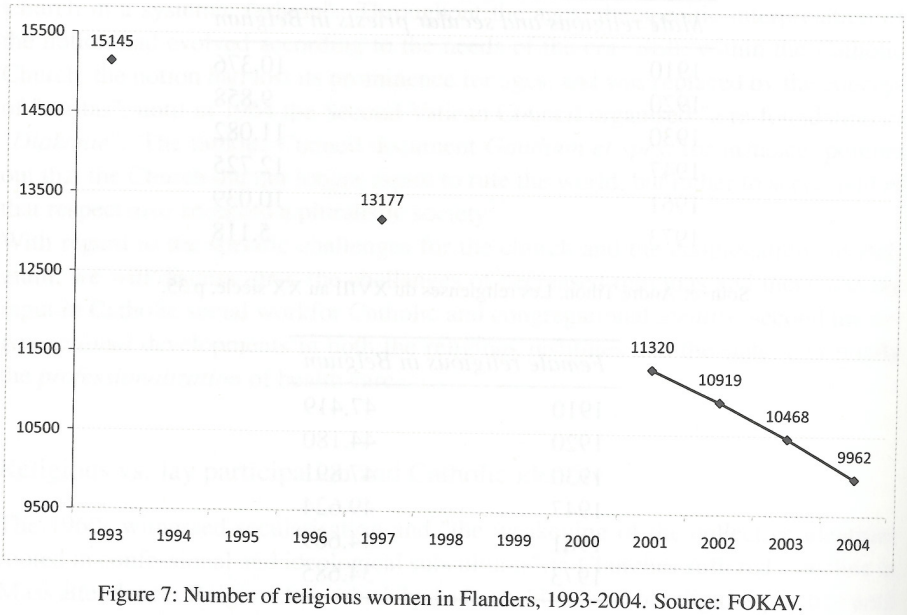
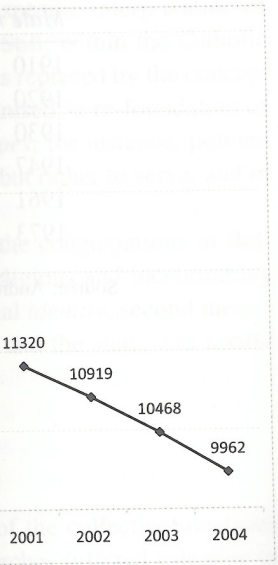


Figure 7: Number of religious women in Flanders, 1993-2004. Source: FOKAV.

Year	Health care	Education	Health care and education	Contemplation (exclusively)	Contemplation & health care or education
			Absolute numbers		
1846	2359	3844	1429	736	736
1856	2481	5309	2075	688	1057
1866	3117	7491	2410	804	1046
1880	4295	10924	3246	1382	3709
1900	5738	17261	6423	1933	9255
1910	8121	25649	8640	5009	13524
1920	8133	24790	7410	3847	10415
1930	9052	26220	8278	4341	13602
1947	10155	26439	8176	4853	13844
			Percentages		
1846	28,19	45,93	17,07	8,79	8,79
1856	23,28	49,83	19,47	6,45	9,92
1866	22,5	54,07	17,39	5,8	7,55
1880	21,29	55,04	16,36	6,85	18,69
1900	18,3	55,05	20,48	6,16	29,51
1910	17,12	54,09	18,22	10,56	28,52
1920	18,4	56,11	16,77	8,7	23,57
1930	18,9	54,74	17,28	9,06	28,4
1947	20,46	53,28	16,47	9,78	27,89

Table 2: Number of religious women active in health care, education or in both apostolic fields. Source: André Tihon, Les religieuses du XVIIIe au XXe siècle, p.40.



04. Source: FOKAV.

templation clusively)	Contemplation & health care or education
736	736
688	1057
804	1046
1382	3709
1933	9255
5009	13524
3847	10415
4341	13602
4853	13844
8,79	8,79
6,45	9,92
5,8	7,55
6,85	18,69
6,16	29,51
10,56	28,52
8,7	23,57
9,06	28,4
9,78	27,89

or in both apostolic fields. Source:

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Thus, congregations were encouraged to make sure that their health care activities regained an apostolic dimension.[33] Indeed, the need for an intensified focus on Christian identity was felt not only in the umbrella organisation but also in the (congregational) hospitals themselves. In the case of the Imelda Hospital in Bonheiden, for instance, the hospital's governance was delegated from the congregation to a separate v.z.w. (cf. below) in the late 1960s and early 1970s. The participation of the congregation members in the hospital diminished greatly. Still, it was probably not a surprise or coincidence that in the very same years the need for a Christian identity within the hospital was reaffirmed. Indeed, in the Autumn of 1972 a task force on Humanisation and Pastoral Work was created.[34] From the 1980s onwards, the specificity of Catholic identity in health care would become further elaborated in the form of an enhanced attention to bio-ethics.[35]

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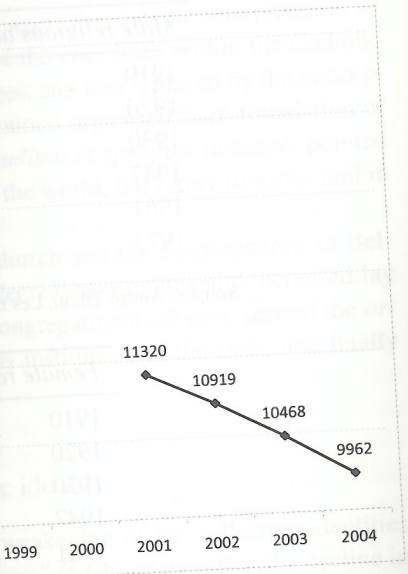
[31] Van Lommel, *Geloof en welzijnszorg*, 69-70.
[32] Depuydt, Ontplooiing van het V.V.I.: 1958-1978, 155.
[33] Suenens, e.a., *Eén van hart en één van ziel*, 416.
[34] Board of Management, Imelda Hospital, 18-10-1972.
[35] Nys/ Schotsmans, Medisch recht en medische ethiek, 298.



nders, 1993-2004. Source: FOKAV.

h care ucation	Contemplation (exclusively)	Contemplation & health care or education
e numbers		
429	736	736
075	688	1057
410	804	1046
3246	1382	3709
6423	1933	9255
8640	5009	13524
7410	3847	10415
8278	4341	13602
8176	4853	13844
centages		
17,07	8,79	8,79
19,47	6,45	9,92
17,39	5,8	7,55
16,36	6,85	18,69
20,48	6,16	29,51
18,22	10,56	28,52
16,77	8,7	23,57
17,28	9,06	28,4
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u XXe siècle, p.40.

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34 Board of Management, Imelda Hospital, 18-10-1972.
35 Nys/ Schotsmans, Medisch recht en medische ethiek, 298.

institutions for youth welfare work" sister Martha, a Dominican Nun, spoke about the new challenges in youth welfare work. She stated that it was no longer enough to raise the youngsters by means of Christian values, or to make good Christians out of them. Indeed, modern society expected a lot more, expected people that would be able to take care for themselves. She even stated that perhaps the sisters had to admit that their lay collaborators stood closer to the sensitivities of actual society. In her view, those lay collaborators, boys with long hair and girls with long, exotic dresses, shared the same living environment of modern youth and thus, sisters had to listen to their lay contribution.[36]

In the domain of welfare and the *"Diakonie"* also, the increased tendency towards pluralism and the downgrading of religion to a private choice undermined ecclesiastical "triumphalism" and thus challenged the social commitment of religious people. An increasing number of social organisations raised questions about the "C" (Christian/Catholic) in their names. On the other hand, Catholics used those challenges to rethink the specificity of Catholic social work and indeed, to reinvent the *"Diakonie"* as the Church's renewed and explicitly formulated role of aid and even service to society. In an age of materialism, *Diakonie* also means fighting spiritual poverty.[37]

Organisational developments in the religious institutions and the state: democratisation

Perhaps the above discussed topic of increased lay participation could in a way be interpreted as a form of democratisation, in the sense of the enhanced participation of lay people in the ecclesiastical structures. In any case, in these exciting years, the Catholic world witnessed another kind of democratisation, namely the decentralisation and increased pluralism within the church. In this chapter we will discuss organisational changes, on three levels: first the organisational developments within the religious institutions themselves; second, organisational changes within the social movements in general; and third, the state will be discussed, more specifically, the impact of increased state intervention in welfare issues.

For the religious institutions themselves, the historical importance of the Second Vatican Council can hardly be exaggerated. The strategy that had been followed since the Council of Trent, the development of a Catholic block focused on a closed, hierarchical church, was now abandoned. Instead a fresh, open Christianity blossomed, which warmly welcomed critical reflection. In a way, one could say that the Church gave up its attempts to form an anti-modern counter society and moved towards a greater appreciation of lay people, leading to greater internal pluralism and differentiation.[38]

In Belgium, the tendency towards pluralism, differentiation and decentralisation was also felt within the structures of Caritas Catholica. Indeed, for some years, Cari-

[36] Martha, *De religieuzen*, 155; about youth welfare work in Germany: Henkelmann/ Kaminsky, *Konfessionelle Wohlfahrtspflege*, 253.

[37] *Kerk ambt diakonie*, 15; Dehaene, *Uw naam is hartstocht voor gerechtigheid*, 15; *Diaconie in het leven van de parochies*, 13.

[38] Hellemans, *Strijd om de moderniteit*, 192-196.

tas had been subjected to intense criticism for what was sometimes perceived as its excessively hierarchical nature. On 15 May 1965, the bishops therefore decided to change the statutes of Caritas and its federations. Its main goals remained the same: coordination, support, representation, integration, and the stimulation of member institutions. But, it was undeniably clear that a new orientation had been chosen. That new orientation was based on several elements. Caritas remained an ecclesiastical structure, but its central responsibilities were now divided among several people, clearly an attempt to weaken the centralised power. Cauwe's position was renamed as that of chairman instead of director-general of Caritas and he received the assistance of two secretaries-general: A. Prims and P. Huvelle. Together with the chaplain they formed the central bureau in charge of the daily governance of Caritas. The relation with the federations was regulated in the Central Council (Centrale Raad), comprised of the chairman of Caritas, the chairmen of the federations and one vicar-general per diocese. Clearly, a tendency towards decentralisation is evident here.[39]

In 1968 Cauwe offered his resignation and was succeeded by Roger Dillemans, a law professor at K.U. Leuven. The integration of religious people and Caritas with society in general was now a new priority, again signalling a shift in focus from the internal hierarchy of the church towards society at large. Dillemans also launched an appeal for better communication via the media. His main challenge, however, was to switch a traditional institution belonging to religious people into an organisation that remained inspired by Christian values but that would increasingly be governed by lay people.[40] In the early 1970s the process towards further decentralisation was even intensified.[41]

The need for more democracy was felt in most organisations of social work, also in the sector of youth welfare work. In her V.V.I. speech mentioned above, sister Martha explicitly raised the question whether the organisations involved in Christian youth work obeyed to a sufficient extent to the needs of modern democracy, whether all collaborators could participate and express their own views sufficiently.[42]

This shift towards a greater decentralisation and questioning of authority also took place within the congregations themselves. Congregation members often gained more individual liberty. For instance, the Gasthuiszusters of Lier were allowed to live in smaller communities, and some sisters even lived alone. Moreover, congregations such as the Gasthuiszusters assumed a more democratic form of governance for themselves.[43] In the Convent of Bethlehem, several participatory institutions were created from the mid-1970s onwards.[44]

Central authority was challenged not only on the organisational level. The 1960s also witnessed a shift in the realm of ideas towards moral and religious pluralism.[45] The

[39] Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*",149-150.
[40] Ibid., 151.
[41] Ibid., 158.
[42] Martha, *De religieuzen*, 156.
[43] Suenens, e.a., *Eén van hart en één van ziel*, 419-423.
[44] Timmermans, *Het Convent van Bethlehem*, 348.
[45] McLeod, *The religious crisis of the 1960's*, 60.

Legal	*Ecclestical*	*Legislation*
vzw Convent of Bethlehem	Convent of Bethlehem	Canon law
Algemene Vergadering (General Assembly)	Algemeen Kapittel (General Chapter)	Chapter law
Raad van bestuur (Board of management)	Superior and 4 assistants	Zending van het algemeen bestuur
Institutions • vzw Vrij Onderwijs Covabe • vzw Gezondheidszorg Covabe (tot 1998)	Local superiors (and council) Congregation	Competences of the local superiors Congregational meetings
Participatory institutions: • Uitgebreide raad (Extended Board) : 1975 - • Intergroep voor religieus gemeenschapsleven: 1975 – (Inter-group for religious community life) • Stuurgroep vorming, 1975 – (Steering Committee for Training) • Uitgebreide stuurgroep economisch beleid, Febr. 1997 – (Extended Steering Committee for Economic Policy) • congregational and local task forces		

Table 3: Organisation chart sisters of the Convent of Bethlehem. Source: R. Timmermans, *Het Convent van Bethlehem*, p.348

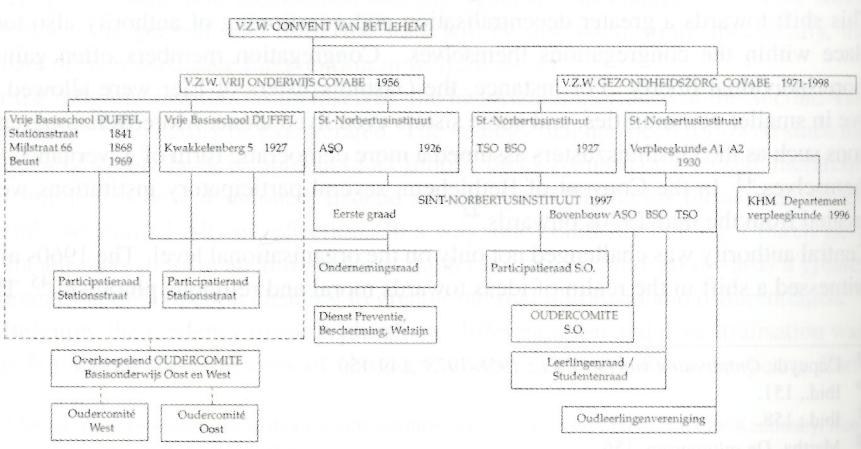

Figure 8: Organisation chart Convent van Bethlehem (until 1998). Source: R. Timmermans, *Het Convent van Bethlehem*, p.426.

	Legislation
hem	Canon law
	Chapter law
istants	Zending van het algemeen bestuur
(and	Competences of the local superiors
	Congregational meetings

75 -
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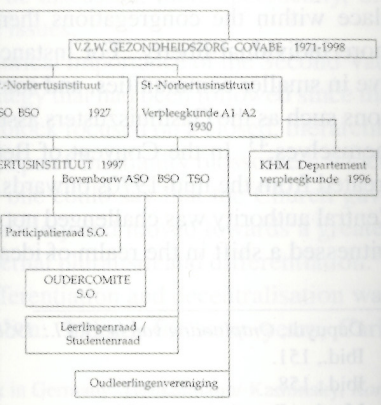

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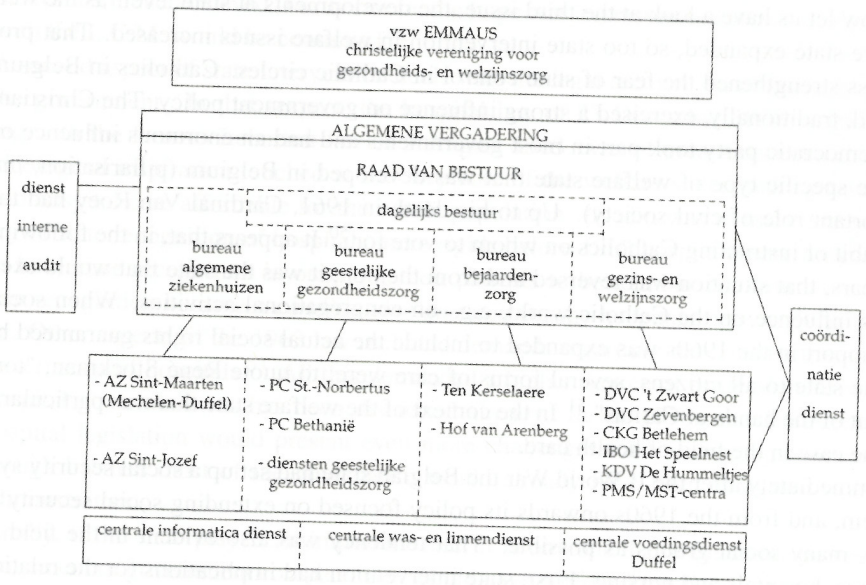

Figure 9: Organisation chart vzw Emmaus (from 1998). Source: R. Timmermans, *Het Convent van Bethlehem*, p.386.

questioning of authority even influenced theology itself. In Christology, for instance, there was a shift from a "Christology from above" (God visited the earth and took a human form) towards a "Christology from below" (starting from the humanity of Jesus).[46] Liberation theology saw its primary task to lie, not in convincing people of the truth of the Catholic message, but rather in liberating the oppressed.[47]

A second level of organisational change deals with the shift in the general nature of the so-called social movements in the 1960s. In earlier periods, social organisations were organised mostly along ideological lines. From the mid 1960s onwards, however, the so-called "new social movements" dissociated themselves from these classical divisions and highlighted new societal cleavages.[48] In those movements, people of several religious denominations worked together fraternally. However, religious people, although prepared to join in those movements, always remained conscious of the importance of spreading Christian values. These included the ethical duty of safeguarding God's creation, thereby reviving the ecological issue. In an age of increasing individualism and materialism, it was considered profoundly Christian for religious institutions to contribute to the proper maintenance of the earth. In that respect, Caritas assumed the goal of providing a sound environment for the future generations.[49]

[46] Burns, *Roman Catholicism after Vatican II*, 21.
[47] Ibid., 24.
[48] Billiet/ Hooghe, *Inleiding*, 322.
[49] Dehaene, *Uw naam is hartstocht voor gerechtigheid*, 17; *Gezonden om te dienen*, 34.

Now let us have a look at the third issue, the developments at state level: as the welfare state expanded, so too state intervention in welfare issues increased. That process strengthened the fear of state control in Catholic circles. Catholics in Belgium had, traditionally, exercised a strong influence on government policy. The Christian-Democratic party took part in most governments and had an enormous influence on the specific type of welfare state that was developed in Belgium (pillarisation, important role of civil society). Up to his death in 1961, Cardinal Van Roey had the habit of instructing Catholics on whom to vote for.[50] It appears that, in the following years, that situation was reversed and from then on, it was the state that would exert its influence on the Catholic world, e.g. on congregational activities. When social support in the 1960s was expanded to include the actual social rights guaranteed by the state to all citizens, several forms of care were, to quote René Stockman, "torn out of the hands of Caritas".[51] In the context of the welfare state that was particularly the case in the field of health care.

Immediately after the II.World War the Belgian state had set up a social security system, and from the 1960s onwards its policy focused on extending social security to as many social groups as possible. That tendency was also evident in the field of care, hospitals and nursing. First, state intervention had implications for the relation between the state and the Catholic organisations, e.g. when it came to health care decision-making (social cooperation). Second, the state devised a system whereby only state-recognised hospitals could receive subsidies and, indeed, could even be given the right to exist. Finally, the federalisation of the Belgian state had implications for health care also.

The democratisation and growing role of the state had profound and specific implications for Catholic care. On the one hand, the state imposed numerous regulations, but on the other, it also gave civil society organisations the opportunity to actively participate in social dialogue. For instance, in the case of hospital regulations, the V.V.I. became an active partner, representing the Catholic world in e.g. R.I.Z.I.V. (the National Institute for Health Care and Medical Insurance), and in several so-called "*paritaire comité's*" (joint industrial committees) etc. Still, although the Belgian model included a fair level of participation, the state kept an important role for itself. For instance, when in April 1971 the V.V.I. heard from the press that the government was planning to introduce profound changes in hospital legislation, the federation felt it had to react. On 28 April it organised a press conference, together with the L.C.M. (Federation of Catholic Mutual Aid Associations), in which they gave their own view of developments. As a direct consequence, the V.V.I. was invited by the government to take part in the negotiations. The V.V.I. agreed that from then on all building activities by health care institutions had to be approved by the government. Nevertheless, the V.V.I. succeeded in realising some important goals, such as the equal treatment of public and private hospitals. Overall, the federation felt relatively satisfied with

[50] McLeod, *The religious crisis of the 1960's*, 74.
[51] Stockman, *De maat van de liefde is liefde zonder haat*, 42.

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the results it had achieved. Furthermore, the hope was expressed that the cooperation with the L.C.M. would be continued.[52]

A second aspect of state intervention deals with the legal recognition of hospitals by the government. In that respect, the hospital law of 23 December 1963, originating with the famous Leburton law of 9 August 1963, was of great importance. Its ideological inspiration touched at the very core of the welfare state: making health and hospital care affordable for the whole population. Its aim was to make the policy of state recognition of hospitals more rigid: before 1963 hospitals were required to have state recognition in order for their patients to be reimbursed; from now on that recognition became a *conditio sine qua non* for the hospitals' very right to exist. Other aspects of the 1963 law included demands regarding the construction and governance of hospitals.[53] All this demanded a higher degree of professionalism in hospital governance, as has been discussed already. In the 1970s and 1980s, new hospital legislation would present even more challenges for the congregations, although by then most of the governance would already have been delegated to lay administrators.

Finally, if the state played an important role, it is obvious that a fundamental rearrangement of government competencies would have profound implications for health care also. From 1970 onwards, the Belgian constitution was changed several times in order to transform the country into a federal state. As a consequence, policy concerning health care would become even more complicated, as several political levels (state, regions) had partial competencies. Even on the level of the Catholic (umbrella) organisations, federalisation had a certain impact. Indeed, the political evolutions presented the V.V.I. also with new challenges, especially from 1974 onwards. Mainly in the French-speaking circles of the federation, the idea gained ground that the regionalisation of the state should also lead to a regionalisation of the V.V.I.. On 8 November 1974, a Walloon Regional Council was established, under the chairmanship of Senator H. Hanquet. The Brussels Council followed on 20 January 1975 and the Flemish Council on 21 March 1975. The reformation was concluded at an important meeting in Heverlee near Leuven, on 4 July 1977.[54]

As a final element, we would like to discuss briefly the limitations and difficulties that the welfare state has experienced in recent years, and the implications for the Christian notions of charity and "*Diakonie*". In that respect, two evolutions were crucial. Firstly, as we have seen in the chapter about the general social changes in the 1960s, Belgian policy in the '60s and early '70s aimed at expanding the welfare state to all citizens, as well as providing enhanced benefits in the so-called residuary systems or "social assistance". Thanks to that expansion, Belgium is considered as having a "strong welfare state", offering maximal protection. However, and this is the second evolution, new challenges from the 1970s onwards (such as the financial crisis) have gravely undermined the very foundations of our welfare state. Nowadays, there is an avid debate about whether the welfare state could and should be able

[52] Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*, 156.
[53] Prims, *Het ontstaan van de ziekenhuiswet in 1963*, 15-16.
[54] Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*, 163.

to protect all the rights of all its citizens, or whether it isn't inevitable that some categories should fall out. In the latter case, some see a renewed role for charity as such.[55]

Both evolutions have aroused profound critique from the viewpoint of "*Diakonie*". The increased state intervention of the 1960's was accused of introducing a cold bureaucracy in the realm of social care. However, the questioning of the welfare state and the so-called neoliberalisation were also confronted by "*Diakonie*" as moving towards individualism and away from social cohesion and justice.[56] In an even more recent context, the Catholic community in Belgium used the notion of "*Diakonie*" to expose the new social challenges of globalisation, such as new forms of social inequality and exclusion.[57]

To conclude our remarks on these organisational aspects in the 1960s: the former dominance of the central authority of the Church shifted towards greater pluralism and decentralisation within the religious institutions and the Catholic pillar. In society as a whole, the welfare state implied a significant increase in state intervention, to which, however, the Catholic pillar neatly adapted itself. In doing so, the pillar kept or even enhanced its authority and function in social cooperation.

Professionalization of care and welfare

As to the aspect of professionalization in welfare, firstly, we will discuss in brief some general views by Caritas Catholica, and secondly we will present a more profound picture of the professionalization process in the specific field of health care.

Caritas Catholica spent a lot of attention to professionalization, as we have illustrated for instance in the case of organisational restructuring and as we mentioned briefly in connection with increased lay participation and catholic identity. In 1970, the views of a Caritas task force on "Welfare and well-being" were presented in a text by Marcel Van Lommel. Although Van Lommel stressed the lasting need for a specifically christian inspiration, he was not blind for the advantages of professionalization. In his view, the professionalization of welfare was a good thing if it enhanced the level of care. Welfare was increasingly arranged and codified into social policy. In all sectors of care, organisations of the private initiative were required to reorganise (professionalise) themselves, for instance in order to obtain state subsidies. Yet Van Lommel concluded, if that process served the goals of the social work of religious people, they should welcome it[58]

Professionalization in health care provides a good example of the above-mentioned. It took place on three different levels: professionalization as the expansion of health care; professionalization on the level of governance and management of the institutions (in the fields of finance, but also medical knowledge and specialisation); and professionalization in the sense of total quality management.

55 Stockman, *De maat van de liefde is liefde zonder haat*, 42.
56 *De diaconie van de Kerk en de plaats van de diaken*, 7.
57 *Diaconie in het leven van de parochies*, 13.
58 Van Lommel, *Geloof en welzijnszorg*, 69-70.

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First, professionalization denotes the expansion of health care. Indeed, the professionalization of health care in the 1960s resulted in an increased tendency to provide health care within specialised institutions, namely hospitals. In Britain, for instance, the hospital sector gained prominence over all other health care institutions in the 1960s.[59] In Belgium too, the hospital sector expanded in these years and even Catholic health care institutions proliferated.

Second, the professionalization of hospital care also had implications for the governance of hospitals. For instance, as to financial elements, it has been written that the financial aspects of the history of catholic health care organisations were among its best kept secrets. Indeed, also for the case of financial management of catholic health care organisations in Belgium in the 1960's, a lot of research still has to be done.[60] We do know, however, that modern financial management was stimulated by Caritas Catholica. From 1963 onwards, the Administrative Center Caritas started to organise the wage administration and accounting of five hospitals, including that of the Convent van Bethlehem in Duffel.

Still, although congregations tried to professionalize their accounting habits and procedures, the growing financial burdens in the course of the 1960's - as a result of expansion and professionalization - could urge congregations to hive off some of their health care activities, such as hospitals. In the case of the Convent Van Bethlehem and one of its hospitals, Imelda in Bonheiden, in April 1970 a vivid debate took place as to whether the clinic should expand rapidly. The physicians advocated expansion, whereas the religious of the Convent tried to slow down the evolution, precisely because of a fear that financial burdens were becoming unbearable for the congregation. Eventually, a separate governing structure was created for that particular hospital (cf infra)[61] From 1977 onwards, the Convent took further steps in modernising the financing techniques of their remaining health institutions, by means of the introduction of the so-called "multi-unit management". That concept denoted more professional financing techniques and elaborated financial administration, techniques that were borrowed from congregations in the United States.[62]

The expansion and professionalization of hospital care made it difficult for the religious to concentrate the leadership of the congregation and hospital governance in the hands of one person.[63] In order to cope with these governing challenges, André Prims, director of the V.V.I. in the period 1958-1966, developed a plan for congregations to update their governance of hospitals. More specifically, Prims devised three steps involving a gradual delegation of the governance of the hospitals by the congregations to governance by separate, specialised bodies (so-called "v.z.w.'s", or non-profit institutions). A first step involved the delegation of all governing functions to a so-called "*beheerscomité*" (or governing committee). The congregation itself would keep only 5 competencies, for which the governing committee only had

59 Berridge/ Webster/ Walt, *Mobilisation for total welfare*, 171.
60 Bakker, *Geld en geloof*, 129.
61 Board of Management, Imelda Hospital, 22-4-1970.
62 Timmermans, *Convent van Bethlehem*, 373-76. About recent years: De Rycke, *Aandacht*, 247-258.
63 Baekelandt, *Verhouding tussen de taken van kloosteroverste*, 154-165.

an advisory role (e.g. in connection with the religious active in the hospitals). A second possibility implied that the congregation would retain ownership of the health care institution, but would delegate complete governance to another, newly established v.z.w., which had the task of governing the institution. A third alternative involved the congregation completely transferring the hospital, including ownership, to the new v.z.w. [64] An example is the Convent van Bethlehem: after the V.V.I. had elaborated these possibilities, the Convent, which owned and ran the Imelda Hospital in Bonheiden (near Mechelen), in 1967 installed a separate "*afgevaardigd beheerscomité*" (governing committee) to which it delegated some - but not all - governing functions. Although some lay persons were included in that committee, the main authority remained in the hands of the religious. In February 1969 the total running of the clinic was entrusted to the v.z.w. Imelda Clinic, and in 1973 it also became the owner of the hospital.[65]

So, professionalization implied the creation of new governing bodies that included specialised lay people. Admittedly, the increasing cooperation between religious and lay people often led to interpersonal friction. Lay people sometimes tended to doubt the professional capacities of the religious care workers. On the other hand, the religious blamed the lay people for seeing their health care activities merely as a job and therefore lacked a sense of responsibility and especially dedication. Some older religious sometimes opposed lay involvement to the extent that they questioned lay authority with arguments of religious authority.[66]

As lay people entered health care institutions and increasingly claimed key positions, the religious either reoriented their focus towards essentially religious activities, or, when they remained active in social work, turned their focus away from specialised sectors towards primary levels of care. Perhaps that adaptation, that shift from specialised care towards essential, base-level assistance can also help explain the renewed focus on "*Diakonie*" as such. René Stockman wrote that the core business of Christian charity today is to place the merely technical and bureaucratic care within "a warm oasis of humanity". Irrespective of the kind of care that is rendered, the basic task of Christian institutions is to provide "a home".[67]

In any case, sisters in congregations were encouraged by the Belgian bishops to become involved in home care and in the activities of the Wit-Gele Kruis (WGK). There was a precedent for this as in earlier times numerous congregation members had been active in the WGK. In 1965, the WGK decided to conclude labour contacts with the sisters on an individual level, rather than through the congregations. This reorganisation resulted in a significant expansion of the WGK, and by 1972, all regions of Flanders were covered.[68] Other religious became involved in various other forms of primary care, for example the care of the homeless or drug addicts, women's shelters

64 Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*, 152 e.v.; Stockman, *Het beheer van congregationele gezondheidsinstellingen*, 325.

65 Timmermans, *Het Convent van Bethlehem*, 374.

66 Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*, 152.

67 Stockman, *De maat van de liefde is liefde zonder haat*, 63.

68 Baré, *Het Wit-Gele Kruis 1937-2007*, 98-99.

or telephone help lines, etc. They became involved also in community work (community houses) or supported attempts to develop an alternative economic system (e.g. the production of ecological products, bicycle workshops, etc.). Many of these new initiatives were financially possible thanks to *Welzijnszorg*, the successful solidarity campaign carried out since the 1960s by Caritas Catholica, or to *Den Oever*, the solidarity fund set up by religious institutes in Flanders. *Welzijnzorg* is presently one of the most dynamic partners in Caritas Catholica Vlaanderen.[69]

A very important aspect of professionalization in the sector of health care was the development and propagation of better medical knowledge. The two examples we would like to discuss are scientific research on hospitals and improved education for nurses. New courses in hospital administration had developed in the U.S. fairly soon after the Second World War. In Europe, the University of Edinburgh followed in 1959 with courses on "Medical Services Training". André Prims, director of the V.V.I. at the time, followed that course and, once back in Belgium set about setting up an academic course on hospital management. A new degree in hospital management was started at Leuven University, and at the end of 1960, a new Centre for Hospital Science was founded. The main inspiration behind those initiatives was the desire of the V.V.I. to offer a more professional education to religious.[70]

Then in 1957 a profound reformation was introduced in nursing education. Nursing training now involved taking a so-called A1 course, namely a third-level, non-university course lasting three years; two years were for general training and the last year offered specialisation in hospital nursing, psychiatric nursing, paediatric nursing or midwifery. However, due to a lack of candidates for that A1 course and the acute need for professionally trained nurses, the training of the so-called nursing assistants was also reformed. Nursing assistants were trained in technical secondary schools, and a third year was added to their course in order to professionalise their training.[71] The question arises whether the religious congregations missed out on the opportunities that enhanced education provided. Although for many the challenge was huge, religious often tried to keep up with the enhanced education. René Stockman, for instance, describes how important the Brothers of Charity considered it to constantly develop their professionalism and expertise. Stockman considered expertise to be "a logical consequence of their fundamental attitude of affection", and says his congregation had always been actively engaged in extra training. Still, although professionalism was important, Stockman states that in the end it was only a means to reach the goal of enhancing the quality of life.[72] So, although *Diakonie* possibly witnessed a movement away from technical care towards primary care, the need for expertise and professionalism certainly was not neglected.

A final example of how religious congregations were confronted with new challenges and professionalization was the introduction into health care of a more patient-oriented approach and the policy of "total quality management" (TQM). Tradition-

[69] ODIS Intermediaire structuren in Vlaanderen 19de en 20ste eeuw.
[70] Depuydt, *Ontplooiing van het V.V.I.: 1958-1978*, 134.
[71] Peers, *Professionalisering, democratisering en rationalisatie*, 288.
[72] Stockman, *De maat van de liefde is liefde zonder haat*, 65-66.

ally, the patient was expected to accept the authority of the physician in a passive manner. Increasingly however, the patient became an active client, maybe even a consumer of care. Patients started to set higher standards and increased their expectations, e.g. concerning information about their illness and prognosis. The patient, and not the doctor or nurse, was now at the centre.[73] The idea of quality management came from the private corporations and was introduced into the world of health care from the 1970s onwards. The Centre for Hospital Science, established at Leuven University in 1961, and from 1970 on devoted its attention to the subject of quality management. The notion of quality (as opposed to mere technicality) in health care offered the religious congregations an excellent opportunity to reintegrate and reaffirm their religious values of "care" (as opposed to mere "cure") within health care. Inside the V.V.I., the commission on Humanisation and Pastoral work was important.[74]

Conclusion

In conclusion, it appears that the realm of Catholic social work in Belgium adapted itself to the new context and challenges in a clever and flexible way.

Firstly, the decrease in membership of religious institutions necessitated a significant increase in lay activity. So, there was a clear tendency towards secularisation, internal pluralism and increased lay participation in social work and health care; yet on the other hand, the Catholic organisations and institutions explicitly and repeatedly reaffirmed the specificity of the Christian inspiration of their social work, e.g. by means of study groups.

Secondly, catholic organisational structures experienced a profound democratization, even within the congregations themselves, and decentralization. Democratization of social care also involved a stronger role for the state. On the one hand, Catholic organisations had to adapt to new rules and regulations. On the other hand, they also succeeded in influencing government policy themselves, as Catholic umbrella groups also retained and even expanded their role in social cooperation.

Thirdly, the development of the welfare state also influenced the organisational and financial structures and habits of Catholic associations and pushed them towards a stronger professionalization, on the levels of governance and modern management, medical specialization and total quality management. Especially the latter item allowed a strong reaffirmation of the specificity of Catholic health care.

The reintroduction of the notion of "*Diakonie*" in the Church in the 1960's on the one hand allowed Belgian Catholics to defend an extended lay influence in Catholic social work , e.g. in the diaconate. Also, it helped them to reaffirm the necessity of spiritual values of serving and "caring", in a society that was characterised, in general, by an increasing individualism and, in the field of health care, by a strong technicality and focus on mere "cure". On the other hand, and although more research may be

[73] Peers, *Professionalisering, democratisering en rationalisatie*, 290.

[74] Timmermans, *Het Convent van Bethlehem*, 382.

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welcomed on this subject matter, it appears that the notion of "*Diakonie*" has not been put into operation widely by Belgian Catholics active in social work.
So, overall, by adapting to the new challenges, the Catholic social institutions retained an important position in health care and welfare, and in some ways even expanded their influence. Where lay people took over tasks increasingly from the religious, still, the Catholic social organisations strongly reaffirmed their Christian values. As to the power of the Catholic pillar as a whole, although it appeared to be threatened, in reality it did not disappear. On the contrary, it kept and perhaps even enhanced its authority and lobbying power.

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